McLean County
Behavioral Health Crisis System

Analysis of System Utilization
and Considerations for System Improvement

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Introduction and Methods

Introduction

McLean County is a community that has considerable strengths, including strong leadership by county leaders, decision-makers, and key stakeholders in addressing the behavioral health needs of residents through cross-sector planning and collaboration. The McLean County Behavioral Health Coordinating Council (BHCC) establishes the priority areas as outlined in the County's most recent Mental Health Action Plan 2022 (MHAP). The coordinated efforts of BHCC and the County have expanded the behavioral health crisis continuum and increased community capacity to address the complex mental health needs of children, youth, and adults through the Frequent User System Engagement (FUSE) program, Triage Center, and the Bridge Academy program. These demonstrations of collaboration, leadership, and committed funding provide a foundation for making significant system enhancements that require ongoing, routine cooperation by providers and stakeholders.

In this report, the TriWest Group consultation team (TriWest) presents findings and action-step recommendations for improving McLean County's behavioral health crisis system for review by the county administrator and BHCC.

Background of the Behavioral Health Crisis System Project

Over the past several years, the McLean County community has become increasingly concerned about the unmet needs of individuals and families experiencing behavioral health (mental health and substance use) crises and the challenges facing the human services system. Significant system concerns include excessive utilization of medical emergency rooms for people with behavioral health needs; excessive demands on law enforcement to respond to individuals experiencing behavioral health crises, resulting in a high volume of avoidable arrests and incarcerations; and observed challenges in meeting the needs of people with a wide variety of behavioral health conditions.

In response to these concerns, McLean County's initial MHAP (2015) identified the need for a robust crisis system that aligned with best practices in the field. To address this need, the County has identified and addressed existing service gaps. For example, the county did not have a 24-hour secure facility (other than medical emergency rooms) that law enforcement or others could bring people experiencing serious behavioral health crises to for assessment, intervention, extended observation (which can often result in diversion from both hospitalization and jail), and/or disposition.

McLean County and community behavioral health providers have taken steps to improve the system. Their actions have resulted in:

- Crisis Intervention Training (CIT) for almost all law enforcement officers
- Expansion of inpatient mental health beds at the Carle BroMenn Medical Center
- Two crisis receiving and stabilization facilities to provide short-term observation and crisis stabilization services to adults in non-hospital-based settings
  - Chestnut Health Systems opened a Crisis Stabilization/Residential Unit (CRU) to provide voluntary detox or mental health support to individuals in crisis for up to 14 days.
  - McLean County established the Triage Center, a 23-hour walk-in center that uses peer support in a living room model.

In addition to strengthening the community's crisis services continuum by providing individuals with somewhere to go, McLean County also established the Frequent User System Engagement (FUSE) program. FUSE is designed to reduce the "revolving door" aspect of mental health crisis services by providing community-based mental health treatment and supports to individuals whose unmet behavioral health needs result in multiple emergency department (ED) visits, stays in jail, and/or visits to the homeless shelter. Nevertheless, emergency rooms have remained the primary receiving centers for county residents experiencing a mental health crisis.

Under the direction of the McLean County behavioral health coordinator, TriWest conducted a review and analysis of the behavioral health crisis system to better understand how people move through the current crisis system and to assess the potential impact of implementing feasible and substantial improvements.

An Ideal Behavioral Health Crisis System

TriWest's view of a comprehensive behavioral health crisis system involves interconnected elements, not just a single program (such as a "crisis center"), service location, or set of services. Optimum performance depends on all elements working together effectively to meet community needs. This coordination does not happen without intentionality and effort by all community partners. Our orientation is consistent with the Roadmap to the Ideal Crisis System (Roadmap) developed by the Group for the Advancement of Psychiatry's Committee on Psychiatry and the Community.[1] The Roadmap describes the core components and values of a successfully implemented comprehensive behavioral health crisis system. It includes three pillars: system oversight and governance (i.e., accountability and finance), a sufficient service continuum, and clinical best practice.

[1] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response*. National Council for Behavioral Health. https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system.

The Roadmap contains a comprehensive review of core components and values of a modern comprehensive behavioral health crisis system. Here, we (TriWest) spotlight key attributes that appear most relevant based on the information we gathered from the McLean County community while specifically examining crisis system flow and costs. Our findings and recommendations align with Roadmap characteristics that can help McLean County implement a high-performing crisis system that may serve as a national exemplar.

Oversight and Governance

Establishing a comprehensive behavioral health crisis system requires an accountable entity that can facilitate a step-by-step, multi-year implementation. Such an entity can be a governmental agency, a nonprofit, or a managed care organization. Regardless of the entity type, it must be able to facilitate interagency collaboration and, in some instances, help finance aspects of the system. The entity must serve as the system's backbone for implementing coordination protocols, best practices, and system monitoring. It also should promote implementation and accountability strategies that involve communicating with the broader community so that residents understand how and when to access crisis services. The recommendations in this report will help McLean County consider future strategic planning, implementation, and evaluation activities that enable the accountable entity to take manageable steps in building partnerships and consensus.

Given the complexity of serving all populations within a given geographic region, behavioral health crisis system oversight and accountability require population health data. An effective system needs reliable and timely indicators to help stakeholders assess the system's accessibility, quality, and capacity to provide services that prevent excessive ED utilization or incarceration whenever possible.

A successful crisis system relies on a culture and practice of collaboration among stakeholders at multiple levels, particularly system leaders who must simultaneously represent the interests of their organizations and the community and set the collaborative tone. The system requires participation from county leaders, health system leadership, funders (such as managed care organizations, foundations, county/city, and others), and all organizations that directly encounter or serve behavioral health clients. Partners in an effective behavioral health crisis system are engaged contributors committed to the success of the overall effort. Although the McLean County stakeholders understand the importance of collaboration, many commented that there have been some historical challenges in establishing shared commitments and partnerships at various levels. It is a significant sign of strength, therefore, that the culture of collaboration is seen to be improving. For example, multiple agencies have worked together on federal grant opportunities in the last 6 months. Beyond the prospect of funding, the grant preparation process can often serve as an exercise that fosters future collaboration.

Crisis Continuum

SAMHSA's *National Guidelines for Behavioral Health Crisis Care* describes a crisis continuum of care with three core service elements:[2]

- regional crisis call center ("someone to call/talk to")
- crisis mobile team response ("someone to respond")
- crisis receiving and stabilization facilities ("a place to go")

These elements already served as BHCC's organizing framework for strengthening McLean County's crisis system. For continuity, this report has also used them as an organizing framework to describe key aspects of the continuum. There are other characteristics of a comprehensive continuum, such as behavioral health first responders and ED staff who are crisis trained, medical triage and screening, transportation resources, and intensive community-based continuing crisis intervention.

Additionally, a key feature of a comprehensive behavioral health crisis system is a centralized crisis hub or crisis response center that includes (or coordinates in real time with) the other system components (e.g., call center, first responders, mobile crisis team, bed-based units/services). The crisis hub/center is a 24/7 secured physical facility where first responders can go and drop off clients. The crisis hub/center should be able to provide medical triage in addition to mental health and substance abuse evaluation, assessment, intervention, and referral.

Historically, behavioral health crisis systems were created to respond only when an affected person is already at risk for ED admission or meets the criteria for involuntary commitment based on risk to self and others. Their primary goals were hospital diversion and prescreening. Even though this approach appears to prioritize access to limited resources, it often results in the unintended consequence that people either do not get served in a timely fashion or only get served when the situation has escalated such that hospitalization is hard to avoid. A behavioral health crisis system that welcomes early requests for help and encourages early engagement promotes a reduction of "crisis tone" in the community and allows more people to get help sooner, with less investment of resource. This is consistent with best practices in population health management. For example, a crisis response center that can provide behavioral health urgent care can prevent emerging behavioral health crises and provide step-down support from ED and inpatient episodes.

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[2] Substance Abuse and Mental Health Services Administration. (2020). *National guidelines for behavioral health crisis care: A best practice toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

Basic Clinical Practice

A crucial goal of the McLean County behavioral health crisis system is that all users (clients and their caregivers/families) experience a *helpful* and *hopeful* response—the right service in the right place for the right length of time—on every occasion. *Basic clinical practice* refers to the accountable entity's assurance that core practices, values, and guidelines are reliably implemented throughout the system, including staff competencies and skills (i.e., training and supervision), effective policies and procedures, and evaluation criteria. This standard of basic practice includes monitoring the appropriate application of behavioral health crisis protocols and eligibility criteria. For example, if there were a rise in first responder secondary transports back to the ED or jail, the accountable entity would conduct a root-cause analysis to inform program or system improvement strategies.

Another key aspect of the basic clinical practice domain is an emphasis on establishing a crisis system that can effectively serve all subpopulations. Subpopulations include all age groups (i.e., children to older adults), regardless of their ability to pay, their clinical conditions (i.e., people with mental health or substance use disorder presentations as well as those with comorbid cognitive disabilities and medical issues), or their non-clinical dispositions (i.e., people who face a variety of issues including educational challenges, homelessness, justice system involvement, and child and elder protective issues; or people with unique service needs such as individuals in the LGBTQ community and individuals/families with a wide range of cultural and linguistic needs, including the diverse and growing immigrant population).

Additionally, federal, state, and local policies often have differing impacts on the delivery of behavioral health services for children, youth, and adults, including the delivery of crisis services. Given the importance of considering services for people of all ages, this report will explicate and stratify the strengths, challenges, and performance of McLean County's crisis system by two age groups: children/youth aged 17 years and younger and adults aged 18 and older.

Methods

TriWest's formative behavioral health crisis system assessment used a combination of qualitative and quantitative data analysis to examine local service delivery efforts and consider potential cost savings for the system while improving care quality and the experience of clients, providers, and first responders. Assessment activities included an on-site visit, key informant interviews with community stakeholders (including medical and behavioral health providers, county-level leaders, children and youth service providers, and first responders), and quantitative data collection and analysis.

TriWest completed more than 40 hours of stakeholder interviews with more than 30 organizations, private practice clinicians, and clients in the community (see

Appendix A: Key Informant Interviews for the list of key informants). We also conducted a 90-minute virtual focus group with 28 community residents.

TriWest worked with key community organizations involved in the crisis continuum to obtain utilization data to analyze how people (children, youth, and adults) move through the crisis continuum.

Summary of Key Priority Considerations for Crisis System Improvement

In addition to examining system flow and monetizing the volume of encounters across the system, we identified some considerations for system improvement that we believe would strengthen the behavioral health crisis system in McLean County. We use the term "considerations" instead of "recommendations" because the local governing bodies and key stakeholders will need to continue this planning work to assess whether these actions are feasible given the political, social, economic, practical, legal, and quality care factors in McLean County. Our proposed actions align with best practices in the field and are informed by the areas of need we observed while analyzing the flow of people through the current system.

Furthermore, we have classified our considerations into three types of change: developmental, transitional, and transformational. These classifications are not definitive but are an initial attempt to help convey how difficult or resource-intensive some changes may be. BHCC members may determine after appraisal that some considerations are more or less complex or burdensome than we initially thought based on our limited knowledge of the stated factors above. These categories are associated with different levels of complexity and resource intensity.

- **Developmental** changes are easier to manage, can be generally accomplished more quickly, are incremental improvements, and are often less threatening to most stakeholders. They often include activities such as rapport and team building, quality improvement activities, or training.
- **Transitional** changes generally take more time to complete (relative to developmental changes) and involve goals that do not have an established action plan. These changes can potentially threaten one or more stakeholders and involve establishing new precedents and ways of operating (e.g., new services, reorganization, or new procedures/workflows).
- **Transformational** changes are substantial, involve restructuring efforts and joint endeavors, and can be the most threatening to stakeholders. These changes can require major shifts in roles and responsibilities, organizational strategy, and vision. These changes can sometimes be difficult to control, and the full impact is not always known.

Table 1: Considerations and Change Types

Consideration	Developmental	Transitional	Transformational
Governance and Oversight			
Establish a governance structure (including an accountable entity, administrative roles, and workgroups) for behavioral health crisis system oversight and monitoring.			X
Conduct a comprehensive self-assessment and develop a system enhancement plan.	X		
Conduct crisis system enhancement evaluation and monitoring based on the enhancement plan.	X		
Establish formal coordination partnerships throughout the system, moving toward a real-time, "air-traffic-control" level of crisis event coordination between system components.			X
Establish formal referral partnerships and protocols with the non-ED receiving centers.		X	
Reconcile service regions and jurisdictions to improve coordination.	X		
Crisis Continuum			
Transition toward a central call center that can respond to behavioral health crisis events regardless of age or insurance status.		X	
Strengthen non-ED receiving centers.	X	X	X
Co-locate the Triage Center with ongoing behavioral health services.		X	
Expand Triage Center services to children/youth and families and sobering services for adults.			X
Re-establish the CRU, including community referral protocols.		X	
Conduct implementation evaluations of all non-ED receiving centers.	X		
Examine clinical workflows to transition to fewer ED-based mobile crisis response encounters.		X	

Consideration	Developmental	Transitional	Transformational
Best Practice			
Conduct a systematic review of all best practices deployed by the system components to establish funding priorities and to ensure that services are aligned with best practice principles.	X		
Establish a crisis training initiative for all health professionals across the system.	X		
Finance standard CIT training with periodic booster trainings for all new law enforcement officers.	X		
Revise non-ED receiving centers' eligibility to allow visits/admissions for people who have a history of violence but are not displaying high-risk signs that indicate a current threat to staff or other clients.	X		

McLean County Behavioral Health Crisis System: Needs and Capacities

In this section, we present the data we gathered to describe the crisis needs and capacities within McLean County. Most of the quantitative data reported herein were collected or shared directly from organizations that responded to our request for information. Where we could not obtain precise quantitative utilization summaries, we made estimates based on information from the organization and regional and national trends.

Characteristics of the McLean County Population

The following table summarizes McLean County demographics. There are 171,256 residents, of whom 5% have no health insurance, fewer than 1% (about 216 people) are experiencing homelessness, and 6.5% (nearly 9,000) are veterans.

Table 2: Demographics of Service Area

Subgroups	Number of People	%
Total	**171,256**	**100%**
Age Groups		
Children (Ages 6 to 11)	12,189	7%
Youth (Ages 12 to 17)	14,890	9%
Adults (Ages 18 and older)	132,510	77%
Young Adults (18 to 24)	27,270	16%
Other Adults (25 to 64)	80,876	47%
Geriatric Adults (65 and older)	24,364	14%
Other Special Population		
With Public Insurance Coverage[3]	44,775	26%
No Health Insurance Coverage[4]	8,230	5%
Experiencing Homelessness[5]	216	< 1%
Veterans	8,620	7%

[3] U.S. Census. (2019). *Explore census data online dashboard*. https://data.census.gov/cedsci/table?q=s2704&g=0500000US17113&tid=ACSST5Y2019.S2704

[4] U.S. Census. (2019). *Explore census data online dashboard*. https://data.census.gov/cedsci/table?q=insurance&g=0500000US17113&tid=ACSST1Y2019.S2701

[5] Homelessness data reported by PATH via the McLean County Regional Planning Commission. McLean County, IL Housing Dashboard. https://mcplan.org/projects-and-programs/bn-home-/mclean-county-housing-dashboard

Prevalence of Serious Mental Illness, Serious Emotional Disturbance, and Substance Use Disorder

The following table summarizes the estimated prevalence of children/youth with serious emotional disturbance (SED), adults with serious mental illness (SMI), and substance use disorders (SUD) among the McLean County population in a given year; these conditions are often associated with a behavioral health crisis. Based on estimates from the National Survey on Drug Use and Health and the National Comorbidity Survey Replication, nearly 9,000 people in the service region have either SED or SMI. About 2,500 are estimated to have co-occurring mental health and SUD, most of whom (90%) are adults with co-occurring SMI and SUD (2,300). More than 11,000 people in the service region are estimated to have SUD, and most are receiving insufficient or no treatment.

Table 3: Behavioral Health Prevalence Estimates in McLean County

Number of People with Behavioral Health Needs in the Past 12 Months			
Mental Health Conditions[6]	**Adults**	**Children/Youth**	**Total**
SMI or SED	6,145	2,708	8,853
Bipolar Disorder[7]	1,887	342	2,230
First Episode Psychosis[8]	16	3	21
All Substance Use Disorders (SUD)	**10,773**	**695**	**11,468**
Alcohol Use Disorder	8,798	336	9,134

[6] Unless otherwise specified, prevalence estimates are based on national, state, and substate rates reported from Substance Abuse and Mental Health Services Administration (SAMHSA) (2019):
National estimates of serious mental illness from the 2018 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.
State estimates of serious mental illness from the 2018 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2018.
Substate estimates of substance use and mental illness from the 2016-2018 NSDUH: Results and Detailed Tables. National Survey on Drug Use and Health Report. https://www.samhsa.gov/data/nsduh/2016-2018-substate-reports.

[7] Kessler, R. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H.-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research, 21*(3), 169–184. https://onlinelibrary.wiley.com/doi/abs/10.1002/mpr.1359.

[8] Kirkbride, J. B., Hameed, Y., Ankireddypalli, G., Ioannidis, K., Crane, C. M., Nasir, M., Kabacs, N., Metastasio, A., Jenkins, O., Espandian, A., Spyridi, S., Ralevic, D., Siddabattuni, S., Walden, B., Adeoye, A., Perez, J., & Jones, P. B. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the social epidemiology of psychoses in East Anglia [SEPEA} Study. *American Journal of Psychiatry, 174*(2), 143–153.

Number of People with Behavioral Health Needs in the Past 12 Months			
Mental Health Conditions[6]	**Adults**	**Children/Youth**	**Total**
Illicit Drug Use Disorder	3,429	448	3,877
Needing but Not Receiving Any or Sufficient Substance Use Treatment	**9,681**	**610**	**10,291**
Co-Occurring Mental Health Condition and SUD[9]	**2,304**	**255**	**2,560**
Need Assertive Community Treatment (ACT)[10]	**73**	**Not Applicable**	**73**

Behavioral Health Crisis Needs in McLean County

Expected Volume of Behavioral Health Crisis Need

The number of people with serious behavioral health conditions is important, yet these estimates do not translate directly into an estimate of the number of crisis events. There is no one right way to measure behavioral health crisis needs for a community. Therefore, we will present data that approximate needs in various ways.

There is strikingly little national benchmarking data on behavioral health crisis needs and response; this issue is only now rising to the level of attention it deserves. Crisis Now, a program developed by McKinsey Health Institute and RI International, published a benchmark based on data from several systems, indicating that communities should expect 230 "behavioral health crisis episodes" per 100,000 people per month.[11] Note that this estimate does not clearly define "crisis," including whether it includes both mental health and SUD crises; nor is there clear benchmarking for the percentage of crises that involve adults versus children and youth. There is also an implication that individuals show up in emergency rooms unless diverted, but this captures only a subset of total behavioral health crisis needs. Based on the McKinsey Health Institute and RI International benchmark, McLean County would experience approximately 391 behavioral health crisis episodes (all ages) per month, or 4,700 episodes per year.

[9] For adults, the number of people with co-occurring SMI and SUD. For youth, the number of people with a co-occurring major depressive episode and SUD.

[10] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services 57,* 1803–1806.

[11] Crisis Now. (2022). McKinsey Health Institute and RI International Launch User-Friendly, Interactive Crisis Resource Need Calculator. https://talk.crisisnow.com/mckinsey-health-institute-and-ri-international-launch-user-friendly-interactive-crisis-resource-need-calculator/

The following table summarizes the estimated annual number of behavioral health encounters for local emergency room admissions and inpatient stays.[12] Although adults experience more emergency room (ER) admissions for suicide and intentional self-inflicted injury crisis overall, the rates are much higher among children and youth (453 per 10,000) compared to adults (143 per 10,000). To a lesser degree, children and youth also have higher rates of ER utilization of non-suicide-related mental health needs (258 per 10,000 people) than adults (241 per 10,000 people). In comparison, adults had higher rates of mental health hospitalization (105 per 10,000 people) than children and youth (75 per 10,000 people).

Table 4: McLean County Emergency Department and Hospitalizations

Utilization	Adults		Children/Youth	
	Est. Number of Episodes Per Year	Episodes per 10,000	Est. Number of Episodes Per Year	Episodes per 10,000
Emergency Department				
Suicide and Intentional Self-Inflicted	1,896	143	1,227	453
Other Mental Health	3,195	241	699	258
Alcohol Use	1,896	143	53	20
Opioid Use	232	18	Not Available	
Substance Use	537	41		
Hospitalization				
Suicide and Intentional Self-Inflicted	1,515	114	360	133
Other Mental Health	1,397	105	203	75
Alcohol Use	505	38	Not Available	
Opioid Use	60	5		
Substance Use	111	8		

We projected monthly and annual estimates of behavioral health crisis events in McLean County based on data from local providers. There were approximately 11,700 events resulting in crisis response in a recent 12-month period.[13] This estimate is more than double the national

[12] Estimates are based on age-adjusted ER rates and hospitalizations for behavioral health needs in McLean County from 2018 to 2020, as reported in the Carle Community Report Card. https://carle.org/about-us/community-report-card

[13] Behavioral health crisis service utilization data were submitted by a variety of county stakeholders including hospitals, PATH, behavioral health providers, and first responders. In some cases, the data were provided as estimates because of data-reporting limitations. For example, some data were adjusted to represent a full 12-month period when the aggregated data were reported for a time period greater or less than 12 full months.

McKinsey Health Institute and RI International estimate of annual crisis events/episodes (4,700) for a population the size of McLean County.[14] The following table summarizes a projection of a typical year of utilization based on data sets provided by local organizations across the continuum of care. We estimate that McLean County will have 11,600 behavioral health crisis events in a typical year.

Table 5: Projections for Behavioral Health Crisis Episode

Measure	McKinsey Health Institute and RI International Estimate[15]	McLean County (Based on System Utilization)[16]
Events per Month	391	970
Adults	Not available	775
Children/Youth	Not available	195
Total Events per Year	4,700	11,600
Adults	Not available	6,700
Children/Youth	Not available	3,300

Examining where individuals in crisis encounter the system is a critical step in understanding how to enhance the system. Across the adult system, most people enter the system through 911 calls (44%), an initial encounter with PATH (28%), or walk-in (self-referral) to the ED (15%). Children and youth events are more likely to originate with the CARES line (58%) or walk in to the ED (19%). Notably, the higher number of children and youth receiving mobile crisis response service with an ED visit is partially attributable to the policy requiring immediate COVID-19 testing. That policy is no longer in effect.

[14] The McKinsey Health Institute and RI International estimate accounts for law enforcement (911) calls, non-ED crisis receiving centers, and mobile crisis, but not non-911 crisis calls (e.g., 211/988). In this comparison, the behavioral health calls to PATH were retained, assuming that in the absence of 211/988 in McLean County, 911 would field many of those calls. McKinsey Health Institute and RI International does not delineate the percentage of behavioral health crisis events that involve adults versus those that involve children and youth. Crisis Now. (2022). McKinsey Health Institute and RI International Launch User-Friendly, Interactive Crisis Resource Need Calculator. https://talk.crisisnow.com/mckinsey-health-institute-and-ri-international-launch-user-friendly-interactive-crisis-resource-need-calculator/

[15] Estimates are based on 230 crisis episodes per 100,000 per month. Crisis Now. (2022). McKinsey Health Institute and RI International Launch User-Friendly, Interactive Crisis Resource Need Calculator. https://talk.crisisnow.com/mckinsey-health-institute-and-ri-international-launch-user-friendly-interactive-crisis-resource-need-calculator/

[16] Because of rounding, column totals may not sum to 100%.

Table 6: Originating Points of Behavioral Health Crises

	Adults		Children/Youth	
Service Type	**Number of Originating Events**	**Percentage[17]**	**Number of Originating Events[18]**	**Percentage[19]**
Initial Crisis Events	**9,300**	**100%**	**2,300**	**100%**
Path 211 (Adults) CARES Line (Children/Youth)	2,600	28%	1,350	58%
911	4,000	44%	450	19%
ED	1,400	15%	400	17%
Mobile Crisis	650	7%	130	6%
Triage	250	3%	Not Applicable	
CRU	150	2%		
Other[20]	150	2%		

Current Behavioral Health Crisis System Map

The following diagram illustrates the flow of clients through the adult behavioral health crisis system and the percentage of people whose crisis episodes were resolved without further penetration into the system. Notably, the nature of flow through the system is variable and non-linear. For instance, many adults moved "backward" through the system in that they first went to the ED before connecting with mobile crisis response. Similarly, very few people flowed into the Triage Center or Crisis Residential Unit (CRU) (when it was in operation) from another point in the system. Among adult crisis episodes, most were resolved through services from the Triage Center (which resolved 89% of its cases), PATH/211 (which resolved 85% of their cases), inpatient hospitalization (which resolved 98% of cases), and mobile crisis response (which resolved 54% of their cases). In contrast, further system penetration often resulted when services were received through 911, first responders, or EDs.

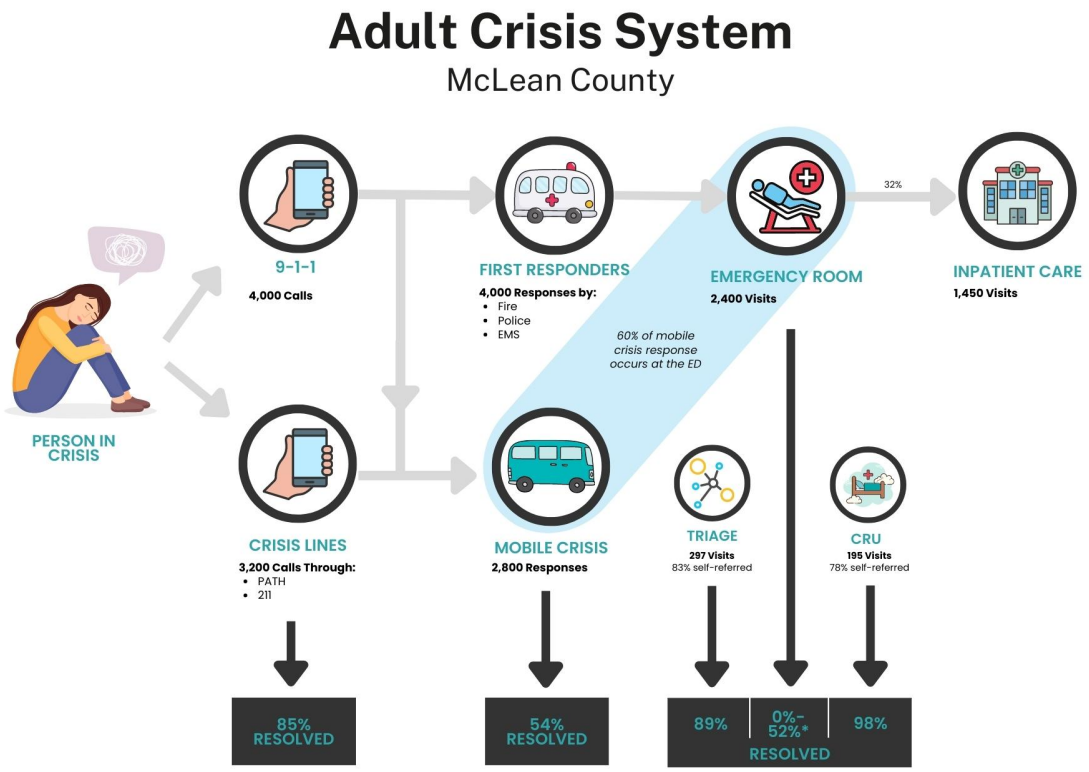
[17] Percentages do not add to 100% because of standard rounding practices.

[18] Because of rounding, column totals may not sum to 100%.

[19] Percentages do not add to 100% because of standard rounding practices.

[20] Includes people who first entered the McLean crisis system through detox, inpatient facility, or unknown source.

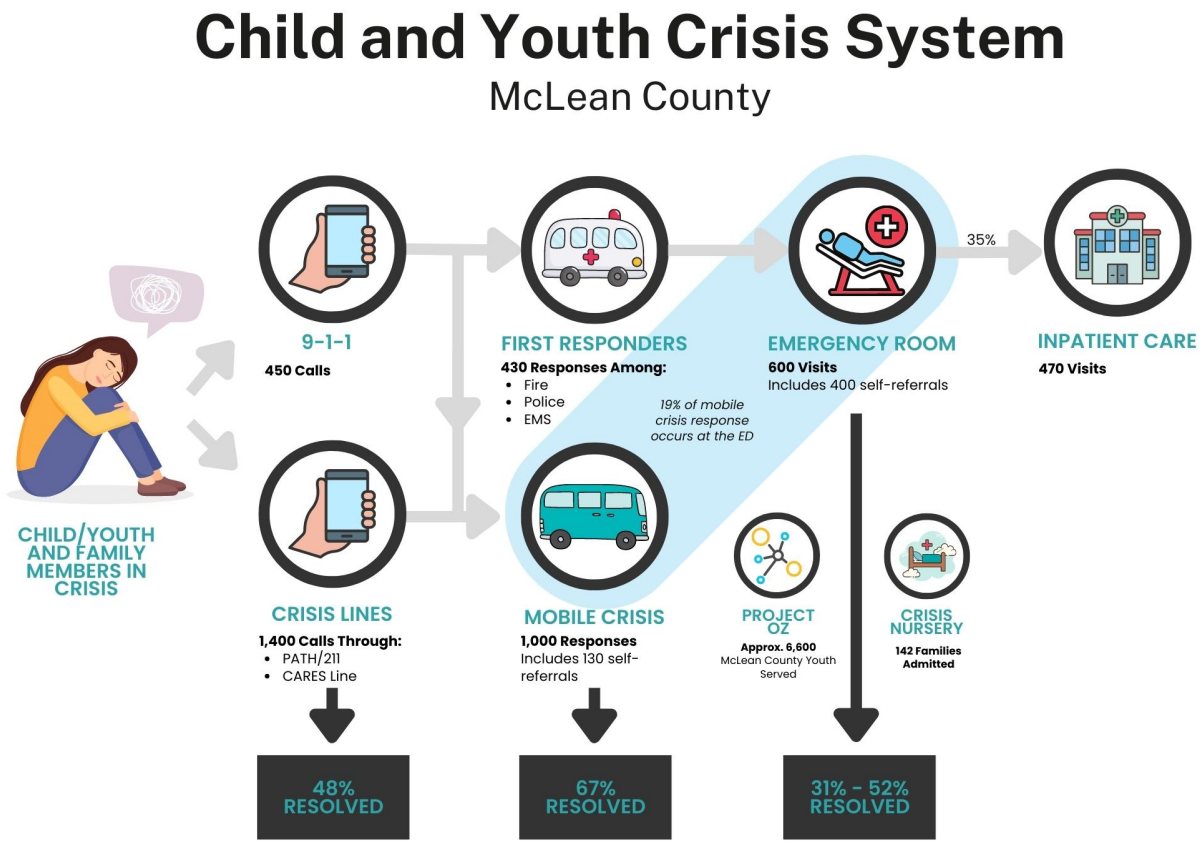
Figure 1. Adult Crisis System



**According to the EDs, as many as 52% of admissions were resolved without further penetration into the crisis system; however, this does not account for the connection with mobile crisis after an admission.*

Among child and youth crisis episodes, most were resolved after receiving services from mobile crisis response (which resolved 67% of their cases) or inpatient care (which resolved 98% of cases). About half (48%) of calls to the CARES line were resolved without further need for crisis intervention. Child/youth-related 911 calls are not currently tracked in the system. Therefore, in the absence of validated call data, we assumed that the ratio of children/youth to adult calls to mobile crisis services was comparable to that of children/youth to adult 911 calls. Crisis episodes often result in further system penetration after receiving services through 911, first responders, or EDs. Notably, no non-ED receiving centers are available for children, youth, and families experiencing behavioral health crises.

Figure 2. Child and Youth Crisis System



**According to the EDs, as many as 52% of admissions were resolved without further penetration into the crisis system; however, this does not account for connection with mobile crisis after an admission.*

Crisis System Encounter Volume Models

Part of a strong behavioral health crisis system is an organizational/governance structure that can routinely collect data to conduct analyses like these more frequently and to produce more accurate depictions of where the system is currently and how potential changes could affect the system. The 2022 MHAP acknowledges that this characteristic is an important feature for improving the continuum of care, including the importance of establishing partnering agreements and governing workgroups for overseeing the mental health system overall. Moreover, McLean County's experience and lessons learned from their involvement with the Data-Driven Justice Initiative and use of the Electronic Justice Information System could be more broadly applied to the entire crisis system and specifically the crisis system. The MHAP 2022 plan presents a conceptual diagram that depicts the key contributors of a cross-system data-sharing plan. This conceptual diagram could be further adapted or modified for the specific purpose of depicting a "real-time/air-traffic-control" level of data sharing and coordination across the behavioral health crisis system.

The current system model below shows the general trends in flow through the crisis system based on quantitative volume data received from organizations across the crisis continuum in McLean County (see Appendix B: Encounter Volume Across the Crisis Continuum). The alternative system model shows an example of trends in flow through the crisis system that more closely align with an ideal crisis system. These analyses are intended to be used for planning purposes. Both models include estimations where quantitative data were not available. In some cases, we asked key informants whether our approximations were reasonable in the absence of precise, validated data.

The figures are read from left to right. Crisis encounters transitioning from another point in the system are depicted by lines entering the crisis component from the left of each setting and exiting from the right. The bar length of each system component is proportional to the number of encounters occurring at that station in the system.

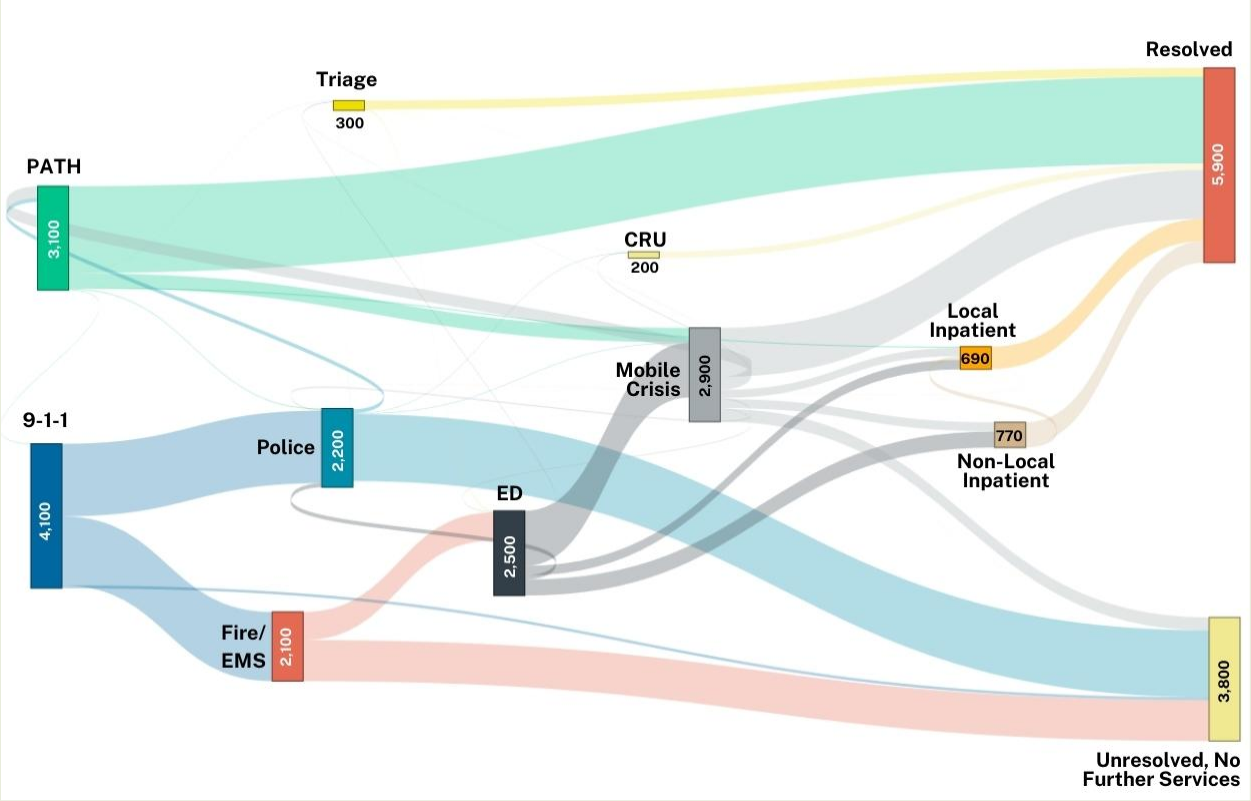
Each behavioral health crisis event that involves interaction with crisis care has one of three outcomes (exit flows):

1. The person flows/transitions to another crisis setting or agency (i.e., further penetration into the crisis system).
2. The crisis is resolved (the person is no longer in crisis or needs crisis services).
3. The crisis is unresolved (i.e., no further interaction occurs in the crisis system, including referral to ongoing services); this may occur when a person refuses care.

Current System Model

The following figure depicts the current adult crisis system, beginning with PATH and 911, the most common point of entry into the crisis system. Whereas most crisis events that result in an interaction with PATH are ultimately resolved, interactions with 911 typically result in a call to first responders (police, fire, or EMS). In turn, a significant portion of these interactions result in further crisis system penetration. In the current model, mobile crisis response services most often occur when someone has an ED admission. The Triage Center and the CRU serve a relatively small number of walk-ins, with very little connection before or after with other crisis system components. The current system experiences more out-of-county inpatient admissions as local inpatient admissions for adults.

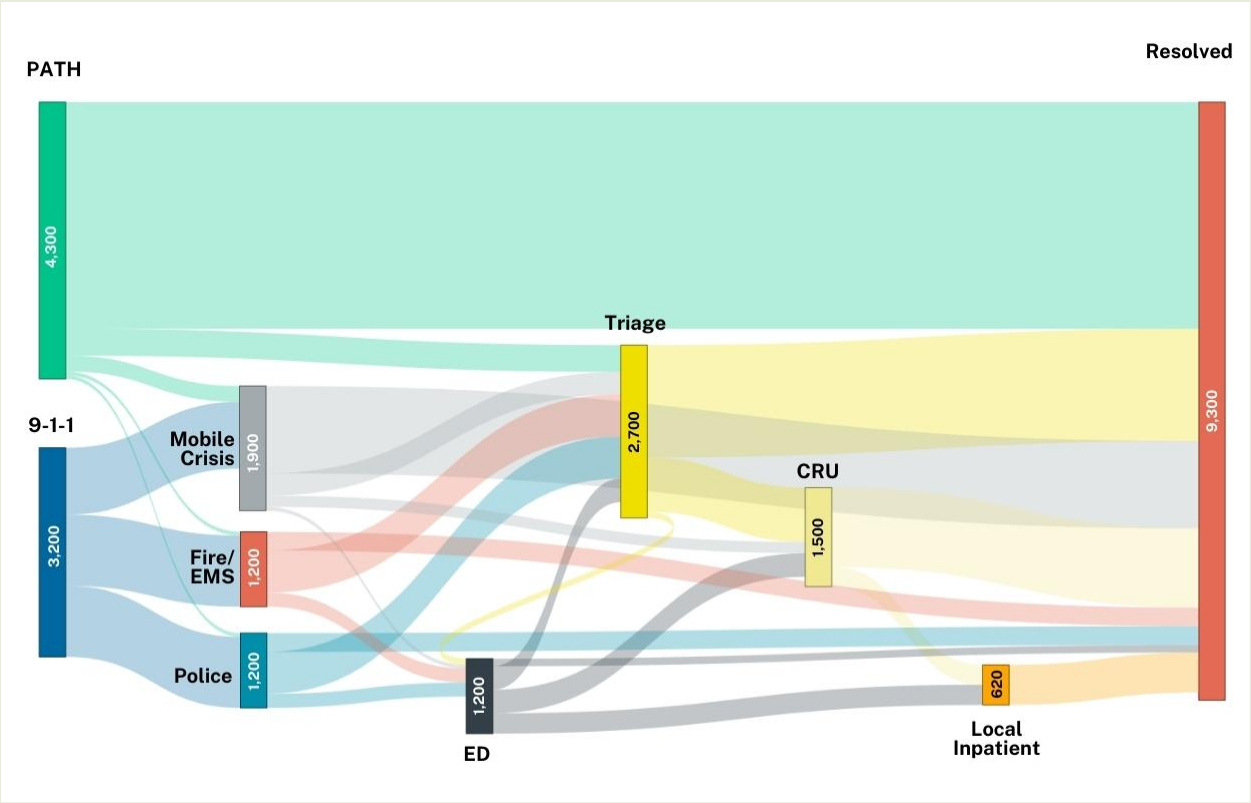
Figure 3: Current Adult BH Crisis System Flow



Alternate System Model

The following figure models a proposed alternate crisis system. This model assumes that effective 988 implementation will lead to a reduction in 911 calls as they would be fielded instead by other crisis lines (i.e., PATH). The alternative model emphasizes mobile crisis response in the field—as opposed to the ED—and establishes a robust workflow/coordination protocol with ED diversion to non-ED receiving centers (i.e., the Triage Center and CRU). In this model, PATH and 911 dispatch refer mainly to mobile crisis response; they also respond to their direct calls from the community. Utilization of the Triage Center is strengthened through enhanced relationships with PATH, ED, and first responders, as well as through a public marketing campaign to increase awareness of Triage Center services. Similarly, this model assumes that CRU will be re-established and that it will have effective referral and coordination relationships with PATH, ED, and first responders. With more crisis events redirected into PATH, Triage Center, and CRU (each with high-resolution rates), more crisis events are resolved without higher intensive levels of care. Additionally, this model results in fewer inpatient stays at the local psychiatric inpatient unit (Carle BroMenn).

Figure 4: Alternative Adult BH Crisis System Flow



Crisis System Continuum Cost Considerations

Based on local system costs reported by organizations associated with key system components (e.g., EDs, Triage Center, CRU, inpatient care) and national estimates of first responder costs, we estimate that the current McLean County behavioral health crisis system costs approximately $32.5 million per year.[21] The following table summarizes the total number of initial crisis episodes and the total number of crisis encounters across the system; for example, there are on average two adult encounters per crisis episode (18,700 encounters divided by 9,300 initial crisis episodes).

Table 7: Estimated Number of Annual Crisis Events, System Encounters, and Total Cost

System	Initial Crisis Episodes	Total Crisis Encounters Across the System	Total Cost
Adult System	9,300	18,700	$25.2 Million
Child System	2,300	4,700	$7.3 Million
Total	**11,600**	**23,400**	**$32.5 Million**

[21] This estimate excludes transportation costs to out-of-county facilities and jail-related costs.

The following are some key considerations when examining current costs:

- Local ED costs appear to be relatively low compared to available benchmark data (the local cost per episode was $214;[22] this figure does not include indirect costs). The Crisis Now national benchmark is $805, which is used with their Crisis NOW calculator, and the Healthcare Cost and Utilization Project estimates that the average behavioral health ED cost is $560 per visit among Midwest EDs.[23]
- In the initial years of operation, the cost for each Triage Center encounter was more than $1,900. This high encounter expense was principally associated with low daily service volume. Comparatively, the unit cost of this level of services is expected to be between $100 to $200 per unit.[24] At the current funding level, the Triage Center would need to serve seven to eight people per day.
- The average length of stay at Chestnut's CRU was 5 days, with an average cost of more than $2,600 per day and more than $13,000 per event. These high-cost encounters are largely the result of very low client volume. Chestnut projects that if they operated at 80% capacity, they would reduce the per diem rate to $400.

This section presents our simulation of the change in the number of service encounters across the adult system, which illustrates the potential impact of enhancing the behavioral health crisis system. **This simulation is offered for system planning purposes only. It provides an example of the kind of simulation that the accountable entity and sustainability workgroup would further refine; it is not intended for immediate fiscal budgeting.** For more resources regarding crisis system funding see the National Association of State Mental Health Program Directors 2022 crisis system funding overview and resources.[25] The following table summarizes one calendar year of current adult crisis system events, including encounters at a CRU. The alternative projection is an example of utilization across the system, assuming each component is effectively implemented, including system oversight and governance.

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[22] Reported by Carle BroMenn; excludes indirect costs and EMS transportation.

[23] Agency for Healthcare Research & Quality. *Substance use disorders in the United States, 2017 #257* (STATISTICAL BRIEF #257). https://www.hcup-us.ahrq.gov/reports/statbriefs/sb257-ED-Costs-Mental-Substance-Use-Disorders-2017.jsp

[24] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response*. National Council for Behavioral Health. https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system.

[25] National Association of State Mental Health Program Directors. (2022). *Overview of crisis funding sources available to states and localities*. https://crisisnow.com/wp-content/uploads/2022/03/20220302_OverviewOfCrisisFundingSources.pdf

National Association of State Mental Health Program Directors. (2022). *Sustainable funding for mental health crisis services*. https://crisisnow.com/wp-content/uploads/2022/01/Sustainable-Funding-Crisis-Coding-Billing-2022.pdf

Table 8: Comparison of Current and Alternative Adult Crisis System Utilization

Estimated Annual Number of Adult Encounters Across Each Crisis System Component		
System	**Current**	**Alternative Projection**
911	4,000	3,250
PATH/988	3,100	4,300
Mobile Crisis	2,750	1,900
Triage Center	300	2,700
CRU	200	1,500
ED	2,450	1,150
Inpatient (non-local)	750	0
Inpatient (local)	700	600
Estimated Crisis System Cost[26]	*$25.2 Million*	*$13.5 Million*

[26] The cost estimates are based on local costs reported by organizations associated with key system components (e.g., EDs, Triage Center, CRU, inpatient care) and national estimates of first responder costs. The alternative cost model accounts for cost savings driven by non-ED-based mobile crisis encounters, non-ED receiving centers operating at scale, and reductions in inpatient admissions and ED encounters.

Considerations for Enhancing the McLean County Behavioral Health Crisis System

Oversight and Governance

Establish a Formal Governance Structure for the Crisis System

The McLean County behavioral health crisis system needs a clearly defined accountable entity. McLean County has no governing body overseeing the behavioral health crisis system.

The BHCC is a volunteer advisory body intended to serve as a "forum to discuss differences, facilitate communication, align strategic plans, and assist with the pursuit of external funding and technical assistance."[27] BHCC appears to be the entity well positioned to help build upon cross-sector engagement and facilitate the establishment of a multi-sector, collaborative leadership structure for the crisis system. The BHCC has limitations in serving as the accountable entity as currently structured. For example, the BHCC charter does not include some key authorities and responsibilities associated with the oversight and governance of a crisis system, such as maintaining interagency collaboration, monitoring system access, ensuring that best practices are implemented with fidelity, establishing effective communication channels, and monitoring system performance. The 2022 MHAP update includes some leadership-related recommendations consistent with establishing a crisis system accountable entity. Although those recommendations are not specific to the crisis system per se, they do share organizational/governing objectives (e.g., create a data governance group for information and data sharing, create and execute Business Associate Agreements for information and data sharing, evaluate dispatch and law enforcement data to identify gaps and needs).

Another limitation to the BHCC developing its role as an oversight and governance body is its open meeting policy. Such policies can hinder workgroup sessions and interagency rapport building among management-level staff, which are vital for establishing cross-sector collaborations and partnerships. If BHCC reconvenes its Community Crisis Planning Committee, it should be able to conduct non-public-facing workgroup sessions.

The following table further describes the governing roles associated with an ideal behavioral health crisis system and accountable entity.

[27] McLean County Board. (2022). *Mental health action plan*. https://www.mcleancountyil.gov/DocumentCenter/View/21891/Mental-Health-Action-Plan-2022-Update

Table 9: Accountable Entity Roles

Governance Roles
Executive Leadership
BHCC could potentially serve as the executive leadership (or governing board) that makes high-level decisions. However, if BHCC were to take on this additional role, the County would need to establish smaller governing groups (e.g., subcommittees and workgroups) that would be responsible for facilitating the progress of key aspects of the system, such as clinical and administrative practices across the system, community awareness/marketing, evaluation/performance monitoring, and coordination of system partnerships (including with first responders and call center leaders). Notably, BHCC has already established a goal to reconvene the Community Crisis Planning Committee, which may be a body that could fulfill one or more of these roles. Together, these groups could provide an accountable operational structure for the crisis system as a whole.
Administration
The accountable entity will need a basic level of administrative support. BHCC already has a full-time coordinating director and assistant director. These positions could assume formal roles responsible for overseeing all crisis system operations, or a specialized coordinator role could be established, which should be distinct, at least in part, from any individual provider or service element and should be accountable to the system's executive leadership. Administration role(s) would be responsible for ensuring that the operational management functions identified below are carried out, such as overseeing indicators of the individual and collective performance of system components, including responsiveness to the needs of primary and secondary customers in the community.
Workgroups
A clinical workgroup would include individuals responsible for clinical operations in their organizations (hospitals, crisis programs, ERs, and others). The task of this group would be to meet regularly (weekly or biweekly at the beginning) and function *as a team* to ensure that individuals do not get stuck in one part of the system because of barriers to access and flow between settings. This group should also involve medical directors as it would work to facilitate smooth transitions for individuals who may have medical needs. One aspect of this work is already underway, as McLean County Center for Human Services (MCCHS) and Carle BroMenn are revising their medical clearance protocol when mobile crisis is dispatched to the ED. Other workgroups that could be established to support system implementation include: • Marketing/public awareness workgroup, which would include training of first responders and other system components (Many stakeholders and community residents have indicated that they were unfamiliar with behavioral health crisis services.) • Evaluation and metrics workgroup responsible for examining key system measures including system access, adequacy, and performance • Sustainability workgroup with an emphasis on considering financing needs and opportunities

Suggested Accountable Entity Activities

- **Systematically review all best practices deployed by the system components.** This would help establish funding priorities that align with best practice principles for modern behavioral health crisis systems, such as addressing recovery needs, including a significant role for recovery support specialists; providing trauma-informed services; emphasizing suicide prevention; ensuring safety for staff and people in crisis; and establishing formal partnerships across the system.[28] This review would also inventory where and when screening, brief interventions, coordination/referrals, and intensive treatment should be implemented. This information would help community partners select and implement clinical and coordination best practices across the system.
- **Monitor program implementation across the system, particularly for newer components.** For instance, in 2020, no formal implementation evaluations tracked the delivery of stakeholder training in new services; assessed the service awareness campaign;[29] analyzed volume/utilization with rapid cycle referral monitoring; or tracked post-service disposition and follow-up. The system would further benefit from selecting and monitoring key performance indicators to determine whether the crisis system is performing as designed and producing the intended coordination and outcomes. Some essential coordination and periodic data monitoring would also help the system with strategic implementation. For example, the 211 program only tracks the caller's demographics (e.g., parent, teacher, concerned adult); it cannot reliably report the age of the person who is principally in need of support/services. System leadership would do well to consider funding and/or seek funding to evaluate and monitor crisis system performance.
- **Reconcile service regions and jurisdictions.** Given the unique mix of service jurisdictions in McLean County, BHCC could collaborate with other service providers to reconcile service regions and jurisdictions that affect behavioral health crisis care coordination, this is a typical challenge of most crisis systems (e.g., Pathways to Success for Youth, the judicial system's Illinois Mental Health Task Force/circuit regions, emergency medical services, and other local behavioral health/crisis-related agencies).

Other Oversight and Governance Considerations

Coordination and Collaboration

Although excellent services exist, the county's crisis system components operate separately rather than in an interconnected, comprehensive behavioral health crisis system. MCCHS has

[28] Substance Abuse and Mental Health Services Administration. (2020). *National guidelines for behavioral health crisis care: A best practice toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[29] BHCC established a goal to conduct a Triage Center marketing campaign in the MHAP 2022 update.

established formal crisis response protocols with the EDs, and staff routinely complete crisis coordination notes for the EDs. Additionally, the Triage Center, EDs, and MCCHS have created a standard intake form that is consistent across settings and intended to minimize the data collection burden for staff and clients. Several agencies have also collaborated on a shared intake form to expedite transition plans. Overall, however, there are basic to minimal levels of interagency collaboration/coordination in McLean County's behavioral health crisis system when compared to the high levels that characterize formal partnerships, such as routine or (even better) "real-time" data sharing.

At the time of this report, the county's 988 program implementation planning is still in process, and there has been no apparent coordination among first responders. Concurrently, the State's Community Emergency Services and Supports Act (CESSA) planning for behavioral health-related 911 calls is still underway and is expected to affect McLean's local system and practices. Additionally, BHCC has the explicit goal of being an engaged stakeholder during the planning process.

Mobile crisis services and the Center for Youth & Family Solutions' (CYFS) Screening Assessment and Support Services (SASS) provide short-term crisis stabilization and care coordination, and they are working to align with mobile response stabilization service best practices. The community values youth mental health and has collaborated to support children and youth with complex mental health needs and their families in the least restrictive settings possible. For example, child and youth mental health care providers have collaborated to submit a SAMHSA grant application for System of Care Expansion funding.

Mental health inpatient planning and coordination are nonexistent with state-run facilities and are characterized as "poor" by clients participating in this assessment. For example, hospitals do not communicate any details regarding inpatient visits to outpatient clinicians overseeing care for those discharged from Carle BroMenn and other inpatient facilities.

System Assessment and Enhancement Plan.

The system would benefit from an assessment and enhancement plan to effectively share and track the status and disposition of a person in crisis, including where they are, how long they have been waiting for services, and their need to advance through the system. BHCC is already planning the development of their crisis-related information exchange; this process ought also to determine the data points that should be shared among agencies involved in the crisis continuum in order to facilitate effective "real-time" coordination and promote more post-crisis follow-up care.

Developing an effective behavioral health crisis system requires attention to the collection and management of the system- and client-level data necessary for system functioning. This is

already a priority for BHCC (i.e., *develop and implement a method for real-time communication between providers of crisis services*). Responsibility for managing the data and the data system ideally falls to the behavioral health crisis system administrator. One crucial element of this process is an EHR portal that can give crisis and outpatient providers access to shared client-level information such as primary service providers, medications, allergies, crisis plan/advanced directives, and care plans. Important elements also include quality monitoring of system-, provider-, and client-level performance indicators such as client flow and continuity (sometimes referred to as "air traffic control") through the entire service continuum (from initial phone contact to ongoing engagement in community crisis services), and service or "bed" registries that identify real-time available capacity across service providers and levels of care. There may be future opportunities for state funding to develop some components of this capacity. For instance, some industry professionals speculate that the community mental health block grant funding crisis set aside percentage may increase from 5% to 10% soon.

Crisis Continuum

Emergency room overload and backup is the most pressing issue to address when imagining a comprehensive behavioral health crisis system in McLean County. There is little psychiatric treatment or consultation capacity in medical emergency rooms. In addition, most individuals who present at emergency rooms are voluntary admissions or have highly acute needs related to mental health or substance use conditions. Although all behavioral health ED visits are appropriately treated as "security risks" regardless of whether they walk in or are brought involuntarily, most of the county's 2,500 emergency room presentations can likely be served in a crisis stabilization/residential unit.

McLean County's continuum of crisis services and supports provides a solid foundation for designing a comprehensive crisis system. The Mental Health Action Plan (MHAP) describes the county as having a robust continuum of crisis services from least to most restrictive.[30] The MHAP also specifically considers the behavioral health needs of children, youth, and families, as distinct from adult needs. The MHAP outlines the crisis system across SAMHSA's three core elements: someone to call, someone to respond, and somewhere to go.

The following table summarizes the key crisis continuum components for children/youth and adults in McLean County. Some components are in place, some need to be enhanced, and a few need to be developed. The McLean County crisis continuum includes most of the core crisis components to some degree, and some (e.g., mobile crisis) are generally considered high quality by those familiar with their services. However, it is essential to reiterate that an ideal

[30] McLean County Board. (2022). *McLean County mental health action plan*. https://www.mcleancountyil.gov/DocumentCenter/View/21891/Mental-Health-Action-Plan-2022-Update

behavioral health crisis system is more than just a list of separate components; rather, a team of components working together.

Table 10: McLean County Continuum of Care

Behavioral Health Crisis Continuum of Care		
System Component	**Adults**	**Children/Youth**
Regional Crisis Call Center ("Someone To Call/Talk to")	PATH/211/988 911 MCCHS	PATH/211 CARES Line MCCHS Project OZ Crisis Intervention
Crisis Mobile Team Response ("Someone To Respond")	MCCHS	MCCHS CYFS – Screening Assessment and Support Services (SASS)
Crisis Receiving and Stabilization Facilities ("A Place To Go")	Triage Center Crisis Residential (Offline) ED Inpatient	Project Oz Emergency Shelter Crisis Nursery ED Inpatient (Outside of McLean County)
Connection to Ongoing Services	MCCHS Chestnut Health Systems Private Providers Higher Education Providers (Younger Adults) FUSE	Bridge Academy (School-Based Intensive Outpatient Program) MCCHS (Community-Based Outreach/Embedded Schools Program) CYFS Youth/Family Intensive Stabilization Program Baby Folds (Respite Care and Therapeutic Day School) Project OZ Youth Empowered Schools Program

Regional Crisis Call Center ("Someone To Call/Talk to")

Several challenges are associated with phone call access for behavioral health services in McLean County. Having "someone to call' is particularly complicated for children, youth, and families experiencing a behavioral health crisis because there is no single crisis service to call. Youth, families, school personnel, community members, and stakeholders are left to discern whether they should call 211 or 988, the CARES line, or Mobile Crisis. MCCHS and CYFS have educated many community providers on the age ranges and funding requirements to access Mobile Crisis and SASS for children and youth. This uncertainty over whom to call during a mental health crisis increases the likelihood that a child or youth will present at an ED for crisis care.

The CARES line is the only entry point to the SASS system for children, youth, and young adults under the age of 21 who are covered by Medicaid in Illinois. The CARES line staff conducts an acuity assessment and determines the need for SASS services. The volume of calls to the CARES line affects the wait time for assessment and, if appropriate, referral to SASS services. McLean County mental health professionals reported wait times of 1–2 hours (or more) for assessment during the past couple of years. Some stakeholders indicated that the CARES line had recently changed to a new system for processing calls and that children and youth's experience getting connected to mobile crisis response services had greatly improved. Additionally, some community members perceive a conflict between the CARES line and 988, as they are two separate call line contractors with apparent redundancies in their scopes of work. Notably, McLean County stakeholders do not have direct oversight of the CARES line.

Additionally, for children/youth in behavioral health crises, insurance status and age requirements determine when, where, how, and who provides services, which delays access to services. In other words, youth and families and service providers must consider insurance status before children, youth, and families are routed to the appropriate crisis provider(s), and they may have to call more than one number to access crisis support. This places an excessive burden on community members to determine the right place to call, which in turn delays access to crisis services for children and families.

Crisis Continuum Consideration

The system would benefit from a gradual transition toward establishing a central call center that can respond to behavioral health crisis events for the whole community regardless of age or insurance status. For instance, SASS only receives reimbursement for cases assessed and dispatched by the CARES line; this is a State-level policy that makes it difficult to develop potential workarounds.

Mobile Crisis Team Response ('Someone To Respond')

Most interviewees indicated that MCCHS provides quality mobile crisis services. However, most mobile crisis calls occur at the ED and MCCHS. The EDs have more than 1,400 walk-ins per year, and most MCCHS mobile crisis calls (60%) occur at the ED, another indicator that alternative non-ED receiving centers are underutilized. Individuals and families are often told to go to emergency rooms; this reduces the potential of diversion to non-ED receiving. Reliance on an ED visit for a behavioral health crisis encounter causes a significant delay in access compared to a mobile response in the community.

Additionally, MCCHS requires medical clearance before deploying teams to the ED. (*MCCHS and Carle BroMenn were revising this criterion at the time of this assessment*). This type of criterion often delays rapid response to behavioral health events. (Notably, this is not a limitation of SASS for children/youth.) Additionally, there are peak periods when a mobile crisis response is

delayed for hours. Establishing a routinely used Triage Center could decrease the frequency of instances when a mobile crisis response team cannot respond to crises within 30–60 minutes. Moreover, it could reduce the response time, permitting mobile crisis to occasionally co-respond with law enforcement or EMS (see below). According to national data on crisis system performance, systems can reduce the utilization of high-end services by developing crisis services that respond early in a crisis and are not in the emergency room.

The capacity of first responders to respond to behavioral health crises could be strengthened in the community. BHCC has established a goal to consider funding additional CIT training, and we expect additional CIT investment to be good for the community. When CIT training was initially provided, nearly all the officers were trained; because of turnover, the percentage of trained officers is now unknown.

Further, mobile response coordination with law enforcement, EMS, and other first responders could create opportunities for deployment of mobile crisis response in the field with the first responder deployed encounters. This would require enhanced call center coordination consistent with a "air-traffic-control" level of coordination and event tracking across agencies.

McLean County does not currently have a co-responder program. A co-responder model was evaluated in 2017, and at that time the program was deemed unsustainable. Still, a component of modern crisis systems is the ability for mobile crisis response to "co-respond" with law enforcement when relevant. In some communities, co-response may involve partnerships with EMS instead of law enforcement. The State of Illinois is currently examining the potential of a co-responder program. There may be applicable lessons in their investigations that could be useful in reconsidering a county-level model.

Crisis Continuum Consideration

- Finance standard CIT training for all new law enforcement officers with periodic booster training.
- Examine 988 call center criteria for determining whether calls are appropriate for law enforcement or mobile crisis; PATH indicated that they follow National Suicide Prevention Line guidelines. Examining these criteria could lead to the development of co-response protocols that are initiated at the call center. Los Angeles County, CA; Harris County, TX; and Travis County, TX are examples of counties that have implemented "co-response" determinations at the call center.
- Explore clinical workflows with the local mobile crisis response teams to assess how to perform more encounters in the community or at a non-ED receiving center.

Crisis Receiving and Stabilization Facilities ('A Place To Go')

Two non-ED receiving centers (i.e., Triage Center and CRU) were established in 2020 to serve the needs of adults with mental health crises. However, no similar receiving/stabilization center is available for children, youth, and families. Despite the absence of non-ED behavioral health

receiving center for children/youth and families—and despite a bifurcated crisis call line and mobile response services—community providers collaborate to prevent or respond to crisis needs of children and youth. Without such facilities, providers have maintained a strong array of home and community-based intensive crisis stabilization services and supports in McLean County. These services have been developed in response to the community's lack of psychiatric inpatient and residential care based on the understanding that children, youth, and families who are experiencing a mental health crisis may need intensive short-term support. Available crisis stabilization services and supports include the Comprehensive Assessment Team, the Youth Intervention Program, CYFS's Family Support Program and Youth/Family Intensive Stabilization Program, Pathways to Success, and Chestnut's Juvenile Justice Program. McLean County children's providers recognize the need to increase the county's capacity to provide intensive home and community-based services and intensive care coordination/High-Fidelity Wraparound to uninsured or underinsured children and youth.[31] Still, we expect that children, youth, and families would be well served to have access to a crisis stabilization unit and a short-term crisis unit.

During FY 2020 and 2021, the Triage Center and CRU were established but considerably underutilized.[32] Both centers reduced or discontinued service due to not being financially viable or low client volume.[33] In 12 months of operation, the Triage Center and CRU were associated with 7% of crisis events (about 500 encounters); in comparison, data from national exemplars predict that these centers should be involved with about half (54%, 6,250) of crisis encounters. Notably, the Triage Center has not been able to fulfill its role as a 23/7 crisis center in McLean County. Initially designed as a 23/7 center, it now operates 19.5 hours per day (7:30 am to 3:00 am) and is available for walk-in or police/EMS drop-off.

The Triage Center and CRU experienced similar difficulties that limited client volume in 2020 and 2021. The following table summarizes the contributing factors associated with the underutilization of the McLean County non-ED receiving centers according to community stakeholders, including leadership from the respective centers. The precise contribution of any one factor cannot be independently quantified; however, the combination of factors described below likely accounts for the most significant challenges.

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[31] Title IV-E Prevention Services Clearing House. (n.d.). Intensive care coordination using High Fidelity Wraparound/High Fidelity Wraparound. https://preventionservices.acf.hhs.gov/programs/330/show

[32] Benchmark data from other systems indicate that the Triage Center and CRU utilization should be much higher relative to psychiatric and ED inpatient utilization.

[33] In 2021, a Carle BroMenn ED visit direct cost $214 per admission (the average total cost of ED visits for behavioral health needs in the Midwest is $560), compared to $1,917 per Triage Center visit or $2,664 per person per day in the CRU. Note that at 80% capacity, the CRU would cost $399 per person per day.

Some difficulties in establishing strong referral lines and regular client volume are attributable to the coincidence of the initial COVID-19 pandemic and in-person meeting restrictions. Moreover, the Triage Center had temporally closed services to the community to deliver telehealth support to first responders exclusively.

The most frequently mentioned challenge among stakeholders was a lack of awareness of service availability, criteria, and accessibility for these centers. For instance, during our review, most key informants, including first responders and clients, were unaware of the availability of or eligibility criteria for the Triage Center or CRU. Although the Triage Center has underperformed per its client volume expectations, we believe that the center has an important role and needs to be expanded to be able to handle more crisis events, including for individuals with complicated conditions and higher acuity.

Table 11: Factors for Underutilization of Non-ED Receiving Centers

Factors for Underutilization of Non-ED Receiving Centers		
Factors	**Triage Center**	**CRU**
Lack of Community Awareness	X	X
Eligibility Criteria	X	X
Service Disruption Due to COVID-19	X	x
No Transport From ED	X	X
Workforce Challenges	X	X
No Implementation Evaluation and System Integration Oversight	X	X
Location Accessibility	X	
Secondary Transport		X
Community Perceptions of Care		X

Some stakeholders indicated that transportation to the facilities was not feasible and a referral barrier. Some cities and programs establish outreach vans, transport coordination, or rideshare arrangements to facilitate transportation to non-ED receiving centers. McLean County first responders indicated that the eligibility criteria were too stringent (e.g., excluding people with *any* history of violence instead of admitting people with a low violence risk level at the time of the referral).

Some delays by the County in responding to emerging challenges in the crisis system can be attributed to not having a dedicated accountable entity. New county-level leadership (i.e., the appointment of a new McLean County Administrator) and a long extensive MHAP update

process that focused on all aspects of the mental health system may have delayed response to emerging needs and challenges supporting the establishment of the non-ED receiving centers.

Additionally, neither the Triage Center nor CRU conducted implementation evaluations or rapid-cycle data-based quality improvement processes that included on referral management and outreach approaches. These types of assessments often include several components (e.g., daily/monthly volume monitoring, demographic analyses, referral tracking, referral source tracking, and client satisfaction monitoring) and can yield actionable volume management strategies (e.g., community training, referral source protocol management, ongoing referral source feedback sessions).

Still, these receiving centers experienced unique challenges that limited service volume in 2020 and 2021. Some stakeholders indicated that the Triage Center's location made client access difficult. CRU/Chestnut leadership found referral performance of community providers to be considerably lacking and a major factor for their inability to maintain operations. This was in addition to dealing with a nationwide behavioral health workforce shortage. Key informants indicated that CRU experienced multiple 'secondary transports' (e.g., law enforcement returning to transport to ED after dropping off clients) after admission. We believe that early (even if infrequent) instances of secondary transports from non-ED receiving centers can create an immediate negative reputation among first responders and considerably limit the likelihood that they will use the center.

Moreover, some stakeholders (including those with close knowledge of program operations) indicated that CRU operations, training, and staffing were inconsistent with the crisis stabilization model (e.g., that it was predominantly operated by medical nurses who were not sufficiently trained to work with clients who had acute mental health needs). The validity of these opinions was not substantiated with any empirical support. Nevertheless, they are shared here because community perceptions like these considerably affect the likelihood that community providers or EDs will choose to make referrals. The Triage Center also experienced staffing shortages and high turnover, including leadership turnover. The Triage Center should be staffed to accommodate 4–5 adult daily visits. Based on their low volume over the first 2 years, the Triage Center would likely be of greater service to the community co-located with existing health or behavioral health providers, where it would be more likely to receive clients and connect them with ongoing services. Regardless, medical screening and intervention capacity should be integrated on site, directly, or through telehealth. Further, the Triage Center should work collaboratively with PATH (the 211 call center) and the mobile crisis providers to provide a single coordinated behavioral health response.

This report emphasizes strengthening the non-ED receiving centers because a) behavioral health crisis estimates and the current pattern of ED utilization make apparent the need for

alternative settings specifically equipped to address behavioral health needs, and b) implementation of the 2021 Illinois Safety, Accountability, Fairness and Equity-Today (SAFE-T) Act[34] is likely to result in an additional 25–50 jailed residents per day who will be best served in these alternative settings such as behavioral health crisis receiving centers including sobering services.

Crisis Continuum Considerations

- Revise non-ED receiving centers' eligibility criteria to allow visits/admissions for people who have a history of violence but are not currently displaying high-risk indicators that they would be a threat to staff or other clients.
- Finance non-ED receiving center implementation evaluations, which include client volume monitoring, high-utilizer monitoring, and client and stakeholder satisfaction (i.e., first responders, ED staff, and other referring agencies.)
- Move the Triage Center to co-locate with other ongoing behavioral health services in the community.
- Expand Triage Center services to include sobering services and services for children, youth, and families, with linkage to Medication-Assisted Treatment programs when applicable.
- Implement a community-wide crisis continuum awareness campaign highlighting new key components including 988, the Triage Center, and CRU (if it is re-established).

Special Consideration: Expand the Triage Center To Serve Children/Youth and Families

Non-ED receiving services are high-value components of a comprehensive crisis system that should be maintained, strengthened, and expanded. Expansion efforts should include an equivalent non-ED crisis stabilization center for youth and families. Children's providers work hard to stabilize children and youth in their homes, schools, and communities. However, there is a complete absence of psychiatric inpatient and residential treatment for children and youth in the community. Intensive home and community-based services are not enough for the small number of children and youth who require short-term placement in an inpatient or residential facility to keep them safe, stabilize their mental health issues, or return their family to a state of equilibrium.

Special Consideration: Expand Triage Center to Sobering

In McLean County, more than 200 people per month present in emergency rooms with active substance use needs/requests, the vast majority of whom are not requesting specific SUD services such as detox. These individuals often spend many hours in the emergency room. Frequent service users, such as those addressed in the FUSE project, are also likely to have SUD. Many individuals with severe alcohol or opioid use disorders benefit from having immediate

[34] Reichert, J., Zivic, A. & Shelley, K. (2021). *The 2021 SAFE-T Act: ICJIA roles and responsibilities*. Illinois Criminal Justice Information Authority. Pertaining to Public Act 101-0652, HB 3653. https://icjia.illinois.gov/researchhub/articles/the-2021-safe-t-act-icjia-roles-and-responsibilities

access to both safe sobering sites as well as the immediate initiation of Medication-Assisted Treatment interventions such as buprenorphine for opioid use disorder and injectable naltrexone for alcohol use disorder. Currently, there is no place where this initiation occurs nor is there a site that facilities connection to ongoing recovery coaching, care coordination, and treatment.

Ideally, the Triage Center would expand its population served and array of services to include any level of behavioral health crisis response that does not require involuntary intervention or the capabilities of a medical emergency room, such as intoxication sobering and medical screening. Specifically, if someone who is intoxicated and suicidal walks in voluntarily to the Triage Center, that person should receive a welcoming engagement, medical (and detox) risk screening, suicide risk screening, crisis evaluation, and crisis intervention, including continuing observation for a period of a few hours if needed. Access to laboratory services and common pharmacological agents is essential as well. The Triage Center currently can respond to mental health risks only and would need to be enhanced to respond to individuals with active substance use and to provide non-ER-level medical screening/intervention (on site or through telehealth). This would likely involve expanding the Triage Center staffing plan to include EMS or medically trained personnel. In this vision, an expanded Triage Center could function independently with the FQHC or be part of the hospital system. It could be funded with a SUD block grant, but it also could be supported by both Medicaid and other insurance when available and by health systems interested in reducing unnecessary emergency room visits and repeat admissions.

Special Consideration: Intensive Short-Term Crisis Intervention Teams

A crisis is not usually a “one-and-done” situation. Although some individuals in crisis can recover simply through referrals to routine outpatient care, this is not often the case. Children, youth, and adults in McLean County have limited access to intensive community crisis follow-up services. These services are an important bridge between higher levels of acute care (inpatient, crisis residential) and more routine continuing care. These services include office- and home-based options and are provided by a multidisciplinary team that includes prescribers, clinicians, case managers, and peers. Further, McLean County has no such services to engage frequent users with persistent, active SUD. There are providers in the community who have experience with the development of these types of services.

McLean County needs greater capacity for these services for adults and youth who are not already engaged in FUSE, Assertive Community Treatment teams, or other high-intensity community services or for those who are too unstable to engage in more routine outpatient care. In addition, it is difficult to transition all Medicaid populations to regular outpatient care because of limitations in access as a result of low payment rates. Therefore, we recommend that McLean County develop intensive short-term (30 days, with some potential for up to 90

days) crisis intervention services for individuals who require that level of intervention—including daily care coordination, medication support, and home visits—to successfully stabilize until they can connect to routine outpatient services. Such services can be for youth or families, adults with SMI or COD needs, and adults with SUD or less severe mental health/co-occurring disorder needs who continue to use and may benefit from intensive care coordination and Medication-Assisted Treatment. Peer support specialists are valuable and often essential members of these teams. These services can be initiated immediately following a crisis intervention (including mobile crisis) or transitioning from a higher level of care such as a crisis residential unit or inpatient. Funding may include a blend of health plan and BHCC funding. In addition, it is possible to develop such services in collaboration with Child Protective Services and Juvenile Justice as a mechanism for diverting selected high-risk youth with behavioral health needs from the juvenile justice or foster care systems.

Special Consideration: Inpatient Mental Health Units and Pediatric Psychiatry

Strategies for expanding access to inpatient psychiatric beds for the most acute and complex individuals (adults and children/youth) must be developed. This may involve the development of more beds or more acute beds, but much can be accomplished through better utilization of existing bed capacity within the community, funding incentives, and improved collaboration. Moreover, the need for pediatric psychiatric services is not limited to the crisis continuum. There has been a long-standing need for psychiatric services for children/youth in the community. The community may benefit from a collaborative, cross-agency recruitment effort for supporting a pediatric psychiatrist or a psychiatric advanced practice nurse practitioner who specializes with children and youth.

Basic Clinical Practice

Although this section focuses on non-ED services, the quality of ED services for behavioral health crises is very important. During client interviews and the community-wide focus groups, many people indicated that they were disappointed in the inability of ED staff and physicians to handle a behavioral health crisis. For instance, ED staff and law enforcement officers reported that some ED visits resulted in secondary transfers to jail as a result of physical encounters between patients and staff.

We highlight these findings to note that some stakeholders believe that the EDs are not fully prepared to manage behavioral health crisis episodes. However, Carle BroMenn Medical Center has one full-time crisis counselor in the ED and is hiring a second, which indicates that they recognize the need to increase ED staff's skills and competencies for helping people in behavioral health crisis. They have also sought approval to embed a behavioral health nurse in the emergency room. Still, all community crisis care providers (including ED staff) need to adequately provide behavioral health services; one or two highly trained personnel are helpful

but not sufficient. For instance, the same level of care quality is expected even when specialty trained staff are on vacation or sick leave. For clients in crisis, their experience in the ED should be the same as it would be in the behavioral health unit. An effective and comprehensive behavioral health crisis system has a culture of best practice skills and aptitudes.

Basic Clinical Practice Consideration

- Assess the prevalence and delivery of behavioral health crisis evidence-based practices (e.g., trauma-informed care, Safe Clinch) across the behavioral health system.
- Establish a training initiative for all health professionals in the system.

Appendix A: Key Informant Interviews

Table 12: Key Informant Interviews

Organization	Interviewee
ABC Counseling	Melissa Box, Clinical Director
Behavioral Health Coordinating Council	John McIntyre, Chairman Susan Schafer, County Board Member
Bloomington Fire Department	Eric West, Fire Chief
Boys and Girls Club	Tony Morstatter, CEO Jennifer Hall, Director of Operations
The Baby Fold	Dianne Schultz, CEO
Carle BroMenn Medical Center	Alicia Allen, Director of Emergency and Trauma Services Theresa Prosser, Director of Medical Surgical Services and Inpatient Services
Center for Youth & Family Solutions	Stephanie Barisch, Director of Therapeutic Services Mychele Kenney, Director of Youth Services
Chestnut Health Systems	Dave Sharar, CEO Matt Mollenhauer, CCO Tammy Rodgers, Director of Behavioral Health Services
Children's Home & Aid	Mendy Smith, Regional VP Tiffany Powell, Program Director
City of Bloomington Police	Kenneth Bays, Assistance Chief of Administration
Heartland Community College	Faye Freeman-Smith, Director of Student Counseling Services
Illinois State University Student Counseling Services	Dr. Carrie Haubner, Interim Director David Adams, PhD, Interim Associate Director
Illinois State University Police Department	Aaron Woodruff, Police Officer
MarcFirst	Brian Wipperman, CEO
McLean County Administration	Cassy Taylor, County Administrator
McLean County Center for Human Services	Joan Hartman, CEO Meghan Moser, Crisis Program Manager Kim Freymann, CCO
McLean County Court Services	Mike Donovan, Director Dennis McGuire, Deputy Director Suzanne Montoya, Director of Juvenile Services
McLean County Sheriff's Department	Jon Sandage, Sheriff

Organization	Interviewee
McLean County Triage Center	Vanessa Granger-Belcher, Director of Behavioral Health Coordination Kevin McCall, Triage Center Supervisor
McLean EMS System	Kris Newcomb, EMS System Manager
NAMI Champaign	Colleen O'Connor, President
NAMI – Heartland Community College	Amy Jeck, Program Assistant
Normal Police Department	Rick Bleichner, Police Chief
OSF St. Joseph Medical Center	Dr. Julie Lewis, MD Gwendolyn Oyer, Case Manager Anthony Repplinger, RN
PATH	Chris Workman, CEO Kevin Richardson, Director of Call Center Operations Liam Wheeler, Director of Homeless Services
Project Oz	Lisa Thompson, CEO
Regional Office of Education #18	Mark Jontry, Regional Superintendent
Regional Office of Education #18	Trisha Malott, Behavioral Health Coordinator
Normal Fire Department	Mick Humer, Fire Chief

Appendix B: Encounter Volume Across the Crisis Continuum

Regional Crisis Call Center ("Someone To Call/Talk to")

PATH operates a call center to assist those in crisis. Based on 2021 data, PATH answers nearly 3,100 adult and 50 child/youth behavioral health crisis calls in a year. Most adult crisis calls (72%) are resolved without needing other behavioral health care, and about 14% require referral to outpatient treatment and the McLean County Center for Human Services (MCCHS) mobile crisis team. A small number of remaining adult calls are connected to an inpatient hospital, law enforcement, 911, or the Triage Center.

Many children, youth, and their family members call the Crisis and Referral Entry System (CARES) line during crisis episodes. There are approximately 1,400 calls to crisis centers for children and youth (including PATH and the CARES line) in a year. Among these, about 48% are resolved without further need for behavioral health services, an additional 48% are connected to mobile crisis, and < 1% receive care at an emergency shelter or are connected to an inpatient hospital.

Based on 911 data from Bloomington and our correspondence with METCOM, we estimate that McLean County has 4,500 behavioral-health-related 911 calls per year. If 911 reflects trends in mobile crisis calls across age groups, we would expect that about 4,000 of these calls are associated with adults and 450 are associated with children or youth. Typically, each 911 call involves one or more first responders, including EMS, fire, or police.

Crisis Mobile Team Response ("Someone To Respond")

MCCHS operates 24/7 mobile crisis services. In 2021, there were 3,171 calls for mobile crisis services from 1,608 callers. Using the demographics of unduplicated callers, we can estimate the following data about crisis calls by age group in any given year.

Table 13: Mobile Crisis Service Utilization

Adults	Children/Youth
Among approximately 2,750 adult calls for mobile crisis: • About 60% are connected through EDs • 24% come from community settings (e.g., doctor's offices, workplaces, homes) • About 16% are connected through PATH • Less than 1% are connected through law enforcement or CRU	Based on data from 2021, approximately 320 youth receive mobile crisis service through MCCHS and 660 receive mobile crisis services through the Center for Youth & Family Solutions (CYFS) CARES line. Among MCCHS mobile crisis calls, 58% are served in EDs and 42% in community-based settings.

Adults	Children/Youth
More than half of these calls are resolved, including 44% of which are connected to outpatient services. Among the 48% of mobile crisis responses that are unresolved, we estimate that approximately: • 13% are connected to 211 • 19% require connection to inpatient care • 14% are unresolved without additional services (such as refusing services) • 3% result in law enforcement outreach, referral to Triage, or admission to CRU or an ED	Among all calls to MCCHS and CYFS mobile crisis services, approximately: • 61% are diverted back to the community with outpatient care • 5% are resolved without further need for outpatient services • 4% refuse care • 30% require additional care, including: ▪ 24% who are hospitalized ▪ 4% who are connected to the CARES line ▪ 2% who are connected to the police, juvenile justice, or the ED

Crisis Receiving and Stabilization Facilities ("A Place To Go")

Table 14: Crisis Receiving and Stabilization Facilities ("A Place To Go")

Non-ED/Inpatient Receiving Centers
Triage Center
In a year's time the Triage Center receives an estimated 300 encounters[35] for adults in crisis per year. Most calls (83%) contact the Triage Center through self-referral/walk-in or community referrals such as primary care physicians, homeless shelters, friends, or family members. About 8% are connected through law enforcement, and 5% are connected through an ED. The rest connect to the Triage Center through mobile crisis (3%) and 211 (1%). The vast majority (89%) of calls to the Triage Center result in resolution either by connection to outpatient care (68%) or with no need for outpatient care (21%). Among the 11% that are not resolved, 9% need additional services through an ED and a small proportion either refuse further care (1%), are connected to crisis residential (1%), or (even more rarely, < 1%) are connected to law enforcement.
Crisis Residential Unit (CRU)
CRU provided data for adult admissions to CRU and detox beds in aggregate. When CRU was in operation, there were approximately 200 adult admissions per year. Most (78%) entered CRU as walk-ins or through community referrals, 15% entered through mobile crisis, 6% were admitted through a law enforcement referral, and 1% through a connection from the Triage Center. Upon leaving the CRU, 98% of crises were resolved, including 86% with a referral to outpatient services, and 2% received connection to residential services.

[35] Referral and disposition data were provided in 2020–2021 aggregate. Therefore, the following breakouts are estimates for 2021 calendar months based on data submitted by the Triage Center.

Emergency Departments
Carle BroMenn Medical Center
Carle BroMenn identified nearly 2,400 behavioral health visits in 2021, about 25% of whom were children or youth and 75% of whom were adults. Among all visits, 60% entered via walk-in, 35% entered through EMS, 4% entered through detox, and 1% entered through the mobile crisis team. Nearly half were resolved in the ED and then connected to outpatient care (47%), and 35% were admitted to an inpatient facility. Five percent resulted in either a disposition to law enforcement, resolution without further need for a referral, or refusal of care, and 3% resulted in detox admission.
OSF HealthCare
In 2021, OSF had 745 behavioral-health-related admissions at the time of the data request. Breakouts by age group, disposition prior to admission, and discharge outcomes were not available. To simulate flows in this project, referral source and discharge outcomes were estimated based on data from Carle BroMenn.

Inpatient Admissions

Mental health crises in McLean County result in inpatient admissions for about 1,450 adult and 470 children/youth in local and non-local hospitals each year, including nearly 160 inpatient admissions among adults at Carle BroMenn. Based on data received from Carle BroMenn and other providers, we estimate that in any given year nearly half (42%) of local adult inpatient visits are admitted from EDs and slightly more than one third (36%) come from mobile crisis response services. In addition, 16% come from another inpatient hospital, and 5% from PATH/211. The vast majority of adult inpatient admissions are resolved (98%). Unresolved inpatient hospitalizations include those sent to another inpatient facility or those involved with law enforcement. The PATH/211 line also indicated that a small portion of their calls (4% of PATH calls, 18% of local inpatient visits) originate from inpatient hospitals; this suggests that upon leaving inpatient facilities, many people are connected to additional resources through PATH. Among child and youth inpatient visits, about half (48%) come by means of EDs and half (52%) come from mobile crisis response services.

Appendix C: Alternative System Utilization Assumptions

- Effective 988 implementation leads to a 20% reduction in 911 calls, which will be fielded instead by crisis lines, including PATH and 988.
- Effective referral and coordination relationships with PATH, EDs, and first responders are established for the Triage Center and a public marketing campaign is created to improve client utilization. This does not include additional client volume if the Triage Center were to adopt sobering services.
- CRU is re-established in the community with effective referral and coordination relationships with PATH, EDs, and first responders. This does not include additional client volume if CRU were to adopt sobering services.
- Among 911 calls, 32% are referred to mobile crisis response, and the remaining involve first responder dispatch.
- Among unresolved PATH/988 calls, 54% are referred to Triage, 32% to mobile crisis response, and the remaining to first responders.
- Among first responder encounters, 25% will be resolved in the community; 75% of the remaining encounters will connect with the Triage Center and 25% with the ED.
- The Triage Center will resolve 65% of its calls; among the unresolved encounters, 90% will flow to CRU and 10% to an ED.
- Among mobile crisis responses, 70% will be resolved without further penetration into the crisis system; among the remaining encounters, 60% will be connected to the Triage Center, 30% will be connected to CRU, and 10% to an ED.
- CRU will resolve at least 90% of its encounters, and the remaining encounters will be directly admitted to an inpatient facility.
- The local EDs will resolve 10% of visits without encountering another system component. Instead of involving mobile response, 35% of unresolved ED visits will be redirected to the Triage Center and 35% to CRU. The remaining 30% of unresolved visits are expected to be admitted to an inpatient unit.